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The Effects of HIV/AIDS on the Quality of Life of Children in Kep, Cambodia

In Cambodia, one of the poorest countries in the world, 40 – 45% of the population earns less than $1 a day (KHANA 2002). With 2.6% of the adults infected, it also has one of the highest prevalence rates of HIV/AIDS in South East Asia. Approximately 160,000 people are currently living with the disease, and an estimated 100 more are infected each day (KHANA 2002). The main form of HIV/AIDS transmission in Cambodia is now heterosexual sex (KHANA 2002). This is partly due to a dramatic increase in husband to wife transmissions, which in turn has increased infections spread from mother to child (Cambodia Red Cross 2004). As a result of the epidemic 60,000 children are affected by HIV/AIDS. It has been estimated that between 2000 and 2004, the number of children orphaned per year due to HIV/AIDS doubled from 30,000 to 60,000 (UNICEF 2004; Aidsmap 2000; Cambodian Red Cross 2004). The total number of orphans to date is over 300,000(Cambodian Red Cross 2004).

Typically children whose parents have HIV/AIDS have a quality of life lower then that of children who are unaffected. Because their parents are ill they do not have the energy level required to work and earn enough money to support their families. This increased risk of poverty in turn affects the amount of food available for the children to eat. Since the parents are incapable of working full-time, the children are often relied upon to perform extra household duties and may be required to find employment in order to supplement the household income. Due to the extra hours required for work, children affected by HIV/AIDS can be taken out of school, subsequently receiving less education than their peers. This type of circumstance also affects the child psychologically. These children typically report being unhappy more often, have fewer friends and less time to play, experience discrimination more often and have lower self-esteem. Due to stigmatization by the community, they typically also have a weak support

structure so there are fewer people willing to help the family. The lack of community support structure also means that when the parents die from the disease the children either have no place to go, since family members and neighbours may be reluctant to take them in due to their association with HIV/AIDS, or they are sent to live with elderly family members who do not have the resources or energy to care for them properly. This leads to an increase in child-led families, poverty, and children on the street or in government run orphanages (Cambodian Red Cross 2004, Barnett and MacMillan 2002).

The Center for International Health at the University of Toronto has been working in the area of Kep, Cambodia, for just over two years, conducting research on primary health care systems in under-resourced settings. The goal of this project was to examine how HIV/AIDS impacts the quality of life of children within the field station catchment area, and evaluate the effectiveness of existing programs aimed at helping these children. This was done through comparison of three groups. Children whose parents have contracted HIV/AIDS and had access to support programs, those whose parents were HIV positive and did not have access to support programs and those parents did not have either HIV/AIDS or access to support programs.

It was found that the children who were affected by HIV/AIDS did experience a quality of life that was lower than those who were not. However, support services run by local NGO's are having positive effects. It was found that children who are affected by HIV/AIDS and have access to support programs have a quality of life much closer to those not affected by HIV/AIDS and higher than those without access to support services.

Methodology

The information in this report is based on interviews conducted in Kep, Cambodia between July and August 2005. Most of the interviewees were children, but if present the parent was also interviewed for additional information. The interviews were divided into 7 sections: demographic information, health issues, household responsibilities and other employment, education, psychological well being, social stigma, and knowledge of and views on HIV/AIDS. The survey contained both structured and open-ended questions.

Three groups of children participated in this survey. The first were children whose parents have HIV/AIDS and who were receiving support services from a local NGO, the Cambodian Development and Relief Center for the Poor (CDRCP). The second group consisted of children whose parents had HIV/AIDS and were not receiving NGO or governmental support. The third group was a control group consisting of children who were not affected by HIV/AIDS and did not have access to support programs.

Each month the families supported by the CDRCP received 30 kg of rice, 1 kg of oil and 0.5 kg of salt. Every 3 months they were also given school supplies and uniforms. In addition to supplying food and material goods, the CDRCP conducted outreach workshops in the villages of these children. The workshops were given over 7 or 8 sessions of 1 hour each and included discussions on commitment to support the community, youth and female empowerment issues, STI's, HIV, AIDS, sexual education and gender roles. Larger functions attended by multiple villages were also conducted by the CDRCP, including karaoke competitions, community discussions, and needs assessments in order to promote HIV/AIDS education, reduce stigma and increase support structures for all village members. The CDRCP supported approximately 90 families in the field station catchment area. 38 children from these families were interviewed.

They were selected using convenient sampling techniques, as only the CDRCP employees knew where they were located and chose who would be interviewed each day

Group 2 were all residents of Chum Cow Bai Village or the "HIV Village". The residents here were originally drawn together by a traditional healer who had acquired, through a dream, the knowledge of the recipe for a tea that would cure their disease. After 3 years, another dream informed him the tea would no longer worked. He has since left the village. Having nowhere else to go, the village residents remained. Originally there were approximately 20 families living in the village, but many have since succumbed to the disease and passed away. Today there are 11 couples left, 4 of whom have children. They receive only a small amount of help from a local missionary. He drives them to the hospital to receive anti-retro viral treatment (ARV), gives them a small amount of rice, and has helped them improve the buildings they live in. The CIH also donates one bag of rice monthly. Four families in this group were interviewed, totaling 4 parents and 7 children.

Group 3 consisted of children from local farming villages in the Kep area. They were neither affected by HIV/AIDS nor received support from governmental or NGO services. 45 of these children participated in the needs assessment.

Results

Demographic Information

Group 1:

The children in this group ranged from 5 to 18 years. The mean age was 10.8 years. 53% of the children were male, 47% female. The majority of these children (46%) had lost their father to HIV/AIDS, 8% had lost their mother, and 36% had lost both their parents. In 11% of

the families both parents were alive but were living with HIV/AIDS. 36% of the parents said either an uncle or an aunt would take care of their children in case they were not able to, while 33% said they either did not know who would take care of their children or their children would be sent to an orphanage.

Approximately 34% of these parents were farmers and 33% were vendors. The rest were either unemployed (11%) or employed by some other means such as fishing (22%). Those who were unemployed said it was due to a lack of energy from their illness.

Group 2:

In the HIV Village, the ages of the children ranged from 5 to 12 years old. The mean age was 9.7 years. 86% of the respondents were male, and 14% were female. Both parents of most of the children were still living, but either one or both of them were HIV positive. The majority (72%) said they had no where to send their children if they were unable to take care of them, while the rest said they would send them to live either with their grandmother or aunt. All of the parents in this group were unemployed due to their illness and lack of energy.

Group 3:

In the Kep villages, the children's ages ranged from 7 to 18. The mean age was 11.4 years. 53% of the children were male, 47% female. 91% of the parents of these children were living and healthy, although 5% had a parent who had some chronic disease. Almost all of these children had a place to go if their parents could no longer take care of them, 48% would be provided for by older siblings and 33% by grandparents. Most of the parents, 57%, were farmers, followed by 19% who were vendors. None of the parents were unemployed.

The mean age for all participants was 10.6 years. There were significantly fewer orphans in group 2 and 3 than in group 1. An orphan is defined as a child who has lost at least one of their parents. The number of children who would not be provided for if they're parents passed away was significantly higher in group 2 than in any other group, although 33% of the children in group 1 were in the same circumstances. This is much higher when compared to the 5% of children who were in the same circumstance in the Kep Villages. 100% of the parents in the HIV Village were unemployed compared to only 11% in group 1 and 0% in group 3.

Health Status

Group 1:

The majority, 53%, of these children said they only had two meals a day, while 47% said they had three. Of these children 37% said they were never hungry, 27% said they were hungry sometimes, and 27% said they were often hungry. Of those who reported not having enough to eat, all said that it was due to a lack of money for food. 46% of these children reported being ill 2 – 3 times a year, while 20% said they were sick 2 – 3 times a month. The majority of the symptoms were fever (37%), and headaches (25%). All of these children had access to some kind of heath service. 53% said they went to the private doctor. Most did not know why, but those that did said it was because the private doctor was closer or because the illness was not serious. 33% of respondents said they used the public hospital; most did not have a reason why. Others said it was either because the illness was serious or the medication was cheaper despite the further distance.

Most of these children were HIV negative (61%), but a sizable proportion was positive, (11%), or their status was unknown (28%).

Group 2:

Though all the children in the HIV Village had three meals a day, they all also reported being hungry because of a lack of food. 57% said they were always hungry and 43% said they were sometimes hungry. All stated the lack of food was due to a lack of money. 32% of these children said they were sick 3 times a month, which is quiet often. Most children reported symptoms that included normal fever (33%), dengue fever (17%), typhoid fever (17%), and abdominal pain (17%). All of these people had access to health care services, and due to the preference of the missionary who aided these people, most of them went to the publicly run hospital in Kompong Trach. Only one mother called the private doctor, because she saw it as more convenient. None of the children were themselves infected with HIV/AIDS

Group 3:

73% of the children in the Kep Villages said they ate 3 meals a day. The remainder, 27%, said they ate 2 or 2 – 3 meals a day. 74% said they were never hungry, 20% said they were sometimes hungry; the rest said they were always hungry or had no response. Of those who said they were hungry, 83% said it was because there was not enough money for food. 48% said they were sick twice a year and 22% said they were sick once a year. The most frequently reported symptoms were headache (32%), fever (23%), and dizziness (14%).

All had access to health care services. 75% used the private doctor exclusively, 15% used the public hospital only and 10% said they used the private doctors usually and the public only when the illness was serious. It was considered extremely socially unacceptable to ask if the child or parent were HIV positive, since the interviews were being conducted without the mediating influence of an NGO who had established this knowledge beforehand. Therefore it is

unknown if any of these children or their parents had HIV/AIDS. Most likely they did not since the majority of their parents were not sick, and those who were had an illness other than HIV/AIDS.

The children in group 1 had much less to eat per day than any of the other two groups, however the children in the HIV Village reported being hungry most often. There was not a very large difference between the numbers of children who said there were times when they were lacking enough money for food. The children in the HIV Village reported being sick most often.

The only group that contained children who had contracted HIV was that associated with the CDRCP.

Household Responsibilities and Other Employment

Group 1:

Aside from the 5% of the children who were considered too young to work, most of the children (26%) were responsible for helping with the household cooking. Other chores included helping with the rice farming (21%), taking care of the animals (usually the cows) (14%), and cleaning (11%). The range of hours spent doing household chores was from 1 – 5 hours a day, with a mean of 2.5 hours per day.

Of these children 58% were also expected to work for employers outside the house to earn extra money. All were employed by their neighbours, the majority, 64%, would help with the rice farming. The money earned from this extra employment was always used to buy household goods, such as food and school supplies for all family members. The amount of paid hours worked also ranged from 1 - 5 hours a day, with a mean of 2.8 hours a day. In total, the

amount of hours children reported working in the day was between 1 and 8, with a mean of 4.8 hours.

Group 2:

The most common household chores for children in the HIV Village were cooking, collecting firewood and fetching water from the pond for the water jars. This was done throughout the day as asked by the parent. None of these children were employed outside the household. Why this is so is unknown, but may be due to the lack of community network to connect these people with their neighbours and provide them with opportunities for employment. No mean number of hours could be calculated, since none of the respondents could give a number for the hours worked each day.

Group 3:

Outside of the 5% of the Kep village children who were considered too young to be responsible for household chores, all other children were expected to help around the house. The most frequently reported chores were: tending to the family cow (22%), cooking (18%), cleaning house (14%) and washing dishes (13%). The amount of time spent doing chores ranged between 1 and 6 hours each day, with a mean of 3.1 hours a day. Of these children 32% also performed other tasks to earn extra money, such as helping with their parents' occupation (e.g. selling traditional Khmer pancakes at local celebration) or farming. Children worked for money as needed, with a mean of 2.2 hours a day. The mean of the total hours work per day was 3.0.

The interviews were conducted in the middle of the wet season when school was on vacation so that children would be available to help with the rice farming. Because of this, the

majority of children reported they were working more hours per day presently than they do during the school year.

Education

Group 1:

All children in group 1 attended school, except for one who was considered too young (97%). The highest level completed by these children was grade 7, the mean grade completed was 3.21. All the children who were attending school were planning to return the following year. 97% said they liked school, mainly because they wanted to learn to have a good job when they grew older and because they had friends there to play with. 72% said they had enough food at school, and 78% said they had enough school supplies. 40% of the children reported being absent from school.

Group 2:

Only one child in the HIV Village attended school, and had been doing so for 3 years. During the school year this child would live with his grandmother, who also paid for all academically related expenses. This was because there was no school within walking distance of the village. Recently a new school had been built in the area, which this boy's little brother would be attending in the new academic year. The other children in the village could not afford to attend school. The one child who did said he enjoyed spending time there, because he wanted to learn to become a teacher. He reported not having enough food to eat while at school, because he had no money to buy snacks, but he did have enough school supplies. He was also never absent from school.

Group 3:

All children in the Kep villages attended school. However, there was one child who due to financial restrains was not returning the following year. The mean grade completed was 3.33. All the children liked school except one, who did not get along well with her teacher. 98% said they were well fed during the school day, while they all said they had enough school supplies. 43% reported being absent from school.

Only 1 of 7, or 14%, of the children who lived in the HIV Village attended school. This is much lower than the other groups and is directly the result of the poverty within the village. All parents said they could not afford the school supplies or uniforms. Out of all the children who attended school in all the groups, only one was not returning the following year due to monetary constraints. Only two children were unhappy at school, but neither was associated with HIV/AIDS. 25% more of the children in the CDRCP group than in the Kep group complained of a lack of food to eat at school. The difference in access to school supplies was less, at only 9%, but it still existed. This shows that even though the children supported by the CDRCP are much more likely to attend school than other affected children they still do not have the same access to resources while there, which may affect their quality of work. However, the dedication of families to their children's education is much higher in affected groups, since approximately 50% less of them reported being absent from school.

Psychological Well-Being

Group 1:

76% of the children supported by the CDRCP reported they were generally happy. Most children reported being content because they had plenty of time to play and many friends to play with. They also enjoyed studying and helping their parents run the household. 74% reported being sad sometimes, mostly because their parents were ill with HIV/AIDS, because they are poor, or because they missed deceased family members. 84% reported having something to be proud of, mostly when they performed well at school or were able to help their parents with their chores or earning money.

Play was an important aspect of the happiness of these children, and 53% of these children reported having time to play. Those who did not said it was because they were too busy helping their parents or studying.

Group 2:

71% of these children reported being generally happy, all said it was because they had time to play with their friends. Although, 57% said they were also sometimes sad, because of their parents' illness.

3 out of the 7 respondents from this village said they had no reason to be proud of themselves, showing a lack of self-esteem. The other 4 said they were usually proud of themselves when playing, for example when they could mould mud or when they were playing sports.

5 of the 7 children reported having ample time to play. The two who did not said it was because they were busy helping their mother around the house.

Group 3:

91% of the children in the Kep villages reported being generally happy, this was because they too had many friends to play with and lots of time to play. Other reasons included being able to help their parents and studying for school. Only 36% of these children reported bouts of sadness. 27% said this was because they had to work, and another 27% said it was because of conflict with others (either they were in trouble with their parents or they fought with other children).

92% said they had something to be proud of themselves for: their ability to study (42%), their ability to play well (30%), and their ability to help their parents (28%). 82% reported having enough time to play. Those that did not said it was because they were too busy helping parents in the house or tending the cow.

The amount of children who reported rarely experiencing feelings of happiness was 20% higher in group 3, than in the other two groups. Similarly, the children supported by the CDRCP experienced feelings of sadness the most often, followed by the children in the HIV Village. Demonstrating that even with support structures in place, parental illness still has a significant effect on the emotional status of children. However, without support structures children did report having less to feel proud about, and so experienced less feelings of confidence. It is also interesting to note that the children in group 1 had slightly less time to play, due to demands at home from their parents. This may be due to the fact that the parents in the HIV Village were

not employed and so had ample time to perform regular household duties without having to rely on the children.

Social Stigma

Group 1:

97% of the children associated with the CDRCP said they had friends, the majority said they had very many. They had friends both at school and around their homes. Those who responded to the question negatively still reported have some friends, but not very many. The reason these three children said they did not have any friends was because the other children were scared of becoming infected with HIV or their parents told them not to play with the child due to their parents HIV positive status. Despite this willingness of the neighborhood children to be friends with affected children 45% reported instances when their friends did not want to play with them. The two reasons given for this was that the children were scared of playing with them when they were sick, because they think they will become infected with HIV, or because of conflict between the children over issues not related to HIV.

Group 2:

All the children in this group reported having many friends. However, since most of these children did not attend school and rarely left the village their friends included only the other children in the village. Only two said they had friends outside the village, one was the only child who attended school, and the other was a child who wandered outside the village boundaries on his own and had befriended other children who lived there. No one reported being treated badly because of their association with HIV/AIDS, and nobody said their friends were

scared of getting infected. 3 of the children reported that their friends could be mean to them, but all said it was because they fought over decisions made while playing.

Group 3:

Only one child in the Kep villages said he had very few friends. He had plenty at school, but none at home because he was always in the field taking care of the family cow. Why this would hinder him from making friends at home he did not know, since most children performed this activity together.

38% said they occasionally felt their friends did not want to play with them. 35% said they did not know why this happened, 29% said it was their own fault for "being nasty", and 24% said it was because of normal differences in opinion between friends.

None of these children reported their friends were scared of becoming sick either from the child themselves or from their parent.

58% said their friends could be mean to them. 96% said it was because of normal differences of opinion, caused by either the child or the friend.

There was not a significant difference in the number of friends reported by the children in each group. However, the percent of children in group 1 who had experienced some kind of discrimination due to their association with HIV/AIDS was 50% higher than other groups, indicating that although they reported having many friends, those friends still treated them differently. Very few of the children in the HIV Village had friends outside of other affected children and so do not present a very good comparison. It is also relevant to report here that when talking to the parents in the HIV Village the majority of them reported a significant amount of discrimination in their home villages. People there would not talk to them or their children,

nor would they buy their products if they sold any. This is one of the reasons the parents remained in the HIV Village instead of returning home after the traditional healer left. This was not reported by the families in the CDRCP group, who all said they had friends and little problems with stigmatization from neighbours.

Knowledge of and Views on HIV/AIDS

Group 3 were also questioned on topics of knowledge of and views on HIV/AIDS Unfortunately this section was not added to the survey until after the other two groups had been interviewed, but nonetheless it adds an interesting point of view on stigma and discrimination within groups of children who are not exposed to the disease.

73% of the children who lived in the villages in the Kep area said they knew something about HIV/AIDS. 69% knew how the disease is transmitted, 17% said it was a very serious disease, 7% said they needed to worry someone in their family would become infected, and another 7% knew some of the symptoms. 56% of the children who knew about HIV/AIDS learned about it from the government advertisements on the radio or the TV, while 24% said they learned about it through listening to people in the village talk. Only 6 of the children said they knew someone with HIV/AIDS, but 64% said they would not play with someone who had HIV/AIDS, because they were scared of becoming ill themselves. 3 of the respondents who said they would play with someone who was HIV positive also said they would not eat with them, because they thought it was unclean and the risk of infection was higher.

Conclusion

Unfortunately, due to the small population size the comparison of groups 1 and 3 with the HIV Village is not a strong one. Further research needs to be done with larger more representative groups to solidify the results exhibited here. Another aspect of this research that could be improved upon is the use of a translator for the surveys. Information is always lost in translation, and additional research without the intermediary influence of a translator would be helpful. Finally, participants were chosen by convenient not random sampling, which weakens the reliability of the results. In further random sampling would be helpful.

In general, the results from this assessment are in favour of the programs run by the CDRCP. Through contributions of clothes, school supplies, food and community education, these programs are improving the quality of life for children affected by HIV/AIDS, raising it above those who do not have access to such support systems. However, this improvement does not eradicate the effects of the disease, as can be seen by the higher level of hunger, poverty, child employment and discrimination in the group associated with the CDRCP when compared to the control group in the Kep villages.

The community support network maintained by the CDRCP ensured discrimination against people living with HIV/AIDS was kept at a level that enabled parents/guardians to find employment by selling goods and to find people who would care for their children if they were too ill, something that would not happen in other villages due to discrimination. The support offered by the CDRCP also increased the amount of food available for the children, decreasing how often they were hungry. A direct correlation between CDRCP support and level of illness cannot be determined from the available data, but it is possible that the support offered did make a difference in the health of the children as they reported to have been sick less often than those

in the HIV Village. The support offered by the CDRCP in addition to the lower unemployment rate also increased the amount of children who had sufficient funding to attend school. It is interesting to note the higher rate of absenteeism in the Kep villages, which may be due to the fact that these children did not have to work as hard to be able to attend school.

Another abnormality was the number of children who were employed outside of regular household duties, which is higher in the CDRCP group than in the HIV Village. The families in this village were significantly poorer than those in the other villages, but yet did not employ their children to earn extra money. This may be because the village was physically isolated from neighbours who would act as employers, or it may be due to stigma associated with HIV/AIDS. This is an issue that requires further examination. However, the highest mean hours worked were in group 3, indicating that even though more children in group 1 were employed to earn money they were not working more hours per day than the children unaffected by HIV/AIDS. There was not a significant difference between groups in the amount of time per day the children had to play.

The children in group 1 experienced a higher level of unhappiness compared to the other children. The exact reasons for this need to be explored further, but this difference shows that even with support systems in place children who are affected by HIV/AIDS are still experiencing increased amounts of dissatisfaction with life. There was not a very large difference between groups in the confidence levels.

The high level of stigma against HIV/AIDS in group 3 is surprising, especially since the percentage of children who said they knew about HIV/AIDS was comparable to those who said they would discriminate against them. The similarities between knowledge and views of HIV/AIDS indicate there may be a correlation between the two. Most of these children had

received their knowledge from government advertisements or from listening to others around the village. This indicates that the government ads may be having adverse effects. People are learning how to protect themselves against the disease, but at the same time are learning to stigmatize people who are already living as HIV positive. Further research into this hypothesis is needed.

There are two main recommendations that can be made based on the results of this survey. First of all, the CDRCP needs more funds to increase the effectiveness of the programs and the amount of people they can reach. Their programs are showing marked positive results, but with more funding the CDRCP could increase the number of people they can reach and the effectiveness of existing programs. Secondly, the HIV/AIDS campaigns funded by the Government of Cambodia were effective, since the children in the Kep villages did demonstrate some knowledge of HIV/AIDS, but they are not as effective as the community outreach performed by the CDRCP. It follows that the government should change it's tactics from broad over-arching educational programs to those that are more open to participation at the community level, which have been shown by the success of the CDRCP to be more effective. Another result of implementing this recommendation would be an increase in the number of people who will access the support programs. One of the main differences between the families associated with the CDRCP and those in the Kep villages was in the number of families who had HIV/AIDS. The Director of the CDRCP, Leng Sothea, stated that when they began their programs very few people would come forth for help, due to a fear of social stigma. This same fear still exists in the Kep villages that have not received help from the CDRCP, as demonstrated by the fact that it was considered highly inappropriate for the interviewer to inquire about the HIV status of any village inhabitant. If the programs run by the government were more participatory and

grassroots in their approach, families living with HIV/AIDS in villages without support would be more willing to use the services already in place.

An initiative by the Government of Cambodia towards community based support programs is underway already, as can be seen in their National Policy on Primary Health Care 2000. Principles two and three of this document highlight the importance of community participation in health and development and of co-operation between different health care organization such as NGO's, private, government and community programs. It outlines the establishment of village health volunteers and village development committees in local communes to facilitate these initiatives. The research done here supports the direction taken by the Cambodian Government in primary health care, and highlights one program that is already highly effective that with more funding would improve its output and also provide a model for programs in other communities.

The next generation of Cambodians are the first to grow up in the tentative peace that now holds the country after the destruction wrought by the Pol Pot regime and the ensuing years of civil war. These children need the best possible environment in which to develop in order to ensure their country continues on the path away from their past of violence and poverty. The HIV/AIDS epidemic threatens the development of the children of Cambodia and therefore the country's future. The CDRCP and other such programs are therefore not only having a positive effect on the HIV/AIDS epidemic in Cambodia, but also on the development of these children. By providing them with further funds and developing similar programs in other areas of the country the Government of Cambodia investing in the future of their country.

Appendix A
Table 1: Survey Results

Demographics	**Group 1**	**Group 2**	**Group 3**	**Chi-Square Value**	**P Value**
Mean Age	10.8	9.7	11.4		
% Orphans	91	29	7	58.2700	0.0000
% With HIV+ Parents	100	100	5	90.000	0.0000
% With No Other Guardian	33	100	5	30.3269	0.0000
% of Parents Unemployed	11	100	0	56.6404	0.0000
Health Status					
% With 3 Meals a Day	47	100	73	10.2495	0.0059
% Who Reported Hunger	54	100 (57 always, 43 sometimes)	26	6.6889	0.0353
% Who Said They Had No Money For Food	100	100	83	6.1020	0.0473
% With Frequent Illness (>1 time a month)	20	49	19	9.6050	0.0082
% of HIV+ Children	11	0	0	5.7283	0.0570
% of Children With Possibility of HIV+ Status (i.e. exposed but not tested yet)	28	0	0	15.3947	0.0005
Household Responsibilities and Other Employment					
Mean Hours Worked per day on Household Chores	2.5	Unknown	3.1		
% Employed for	58	0	32	13.1557	0.0014

Money					
Mean Hours Worked for Money	2.8	0	2.2		
Mean Total Hours Worked	4.8	Unknown	3.0		
Education					
% Enrolled in School	97	14	100	64.4756	0.0000
Mean Grade Completed	3.21	3	3.33		
% Who Will Continue in the New School Year	100	100	98	0.8771	0.6450
% Who Like Attending School	97	100	98	0.0395	0.9804
% Who Have Enough Food At School	72	0	98	14.8427	0.0006
% Who Have Enough School Supplies	78	100	87	0.4433	0.8012
% Who Have Been Absent From School	40	0	84	8.3443	0.0154
Psychological Well-Being					
% Who Are Generally Happy	76	71	91	5.8748	0.0530
% Who Experience Feelings of Sadness	74	57	36	25.6006	0.0000
% Who Have Something To Be Proud About	84	57	92	6.4611	0.0395
% Who Have Time To Play	53	71	82	5.5115	0.0636
Social Stigma					
% Who Have Friends	97	100	100	2.7990	0.2467
% Who's Friends Have	45	43	38	0.4217	0.8099

Said They Do Not Want To Play With Them					
% Who Have Experience Discrimination	50	0	0	32.9577	0.0000
Knowledge of and Views on HIV/AIDS					
% Who Said They Knew About HIV/AIDS	N/A	N/A	73		
% Who Had Knowledge of HIV/AIDS	N/A	N/A	73		
% Who Would Not Be Friends With Someone Who Is HIV Positive	N/A	N/A	64		
% Who Would Not Eat to Buy Items From Someone Who Is HIV Positive	N/A	N/A	7		
% Who Discriminate Against People With HIV/AIDS	N/A	N/A	71		

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